STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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Governor

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Testimony by Doreen Del Bianco, Legislative Program Manager Department of Mental Health and Addiction Services Before the Program Review and Investigations Committee September 26, 2013

Good Afternoon Senator Kissel, Representative Mary Mushinsky and distinguished members of the Program Review and Investigations Committee. I am Doreen Del Bianco, Legislative Program Manager for the Department of Mental Health and Addiction Services, and I am here today to speak to the issue of Hospital Emergency Department Use and Its Impact on the State Medicaid Budget. With me today is Michael Michaud, Chief of Staff to Deputy Commissioner Paul Di Leo, who is here to answer any questions you may have.

According to the CT Department of Public Health, in 2010, the number one cause of hospitalization for people aged 15-64 years was "mental disorders." DMHAS believes that individuals with serious behavioral health needs should receive treatment in the least restrictive community setting, reserving the use of inpatient treatment to only those instances when medically necessary.

In collaboration with Advanced Behavioral Health, Inc. (ABH) DMHAS has implemented the **Intensive Case Management (ICM)** program to deliver outreach and engagement for individuals who meet high utilizer criteria (e.g., 4 or more acute care admissions within 6 months, 2 acute admissions in 30 days). The ICM served 1,832 individuals in FY 13. Eighty-four percent of those served by this program have either partially or fully met their recovery goals, which most often focus on housing, employment and an increase in their overall functioning.

DMHAS **Behavioral Health Emergency Department Collaboratives** are currently occurring in Hartford, Middlesex, and New Haven. The collaborative aims to prevent or reduce avoidable presentations to area hospitals and includes the DMHAS Local Mental Health Authorities, area hospital inpatient and emergency department (ED) staff, CT Behavioral Health Partnership staff, ABH staff, and other relevant providers. Focus is on individuals identified as high utilizers of EDs as well as individuals with complex and service intensive needs in both the EDs and mental health inpatient units.

- **Hartford area ED** efforts include CRMHC, Hartford Hospital and St. Francis Hospital.
- **New Haven area ED** efforts include the Acute Services Division at Connecticut Mental Health Center (CMHC) and the Crisis Intervention Unit at Yale New Haven Hospital. The focus is on diverting clients from the ED who can safely be referred to CMHC instead for outpatient follow-up.
- **The Middlesex area Community Care Team (CCT)** is a collaboration of nine community agencies that specialize in care delivery for people with serious mental illness and/or substance abuse in Middlesex County. In a 6-month period, the CCT managed a cohort of individuals with highly complex behavioral health needs and demonstrated a 52% reduction in emergency department and inpatient visits (i.e., 924 visits pre CCT vs. 478 total visits post CCT). The Connecticut Hospital Association (CHA) has recognized Middlesex Hospital for their exemplary work on the CCT.

We are working closely with the general hospitals regarding wait lists to our state beds so they will now admit individuals with serious mental illness who are in their emergency departments to their psychiatric units and we are prioritizing those admissions. We post bed availability on our web site and list the hospitals that have

patients waiting for beds and their status. As of this morning, there were no patients in emergency rooms waiting for a state bed; all individuals were in an inpatient setting.

There are also a number of initiatives that we are either beginning to explore, expanding, or are part of the our overhaul health care system that we believe will address the issue of emergency room use. They are as follows:

- DMHAS has proposed to CMS a transformation of our state-wide Local Mental Health Authority (LMHA) recovery oriented system of care by implementing the **Connecticut State Transformation: Accelerated Access to Recovery Reforms (CSTAARR)**, a care delivery and payment reform model specifically for persons with serious behavioral health needs. We know that many of these individuals frequent hospital EDs and oftentimes become hospitalized for avoidable ambulatory-sensitive conditions because their medical and behavioral health needs are not being met by our current recovery oriented system of care. **CSTAARR** plans to address this issue by utilizing a primary care capable, Rapid Access delivery model for mental health outpatient services that meets the needs of people in the community and prevents unnecessary use of hospital-based care. The department has high hopes for this model even should CMS not select the project for funding, as it meshes well with DMHAS' **Behavioral Health Homes** (BHH). Health Homes are yet another way in which the department hopes to cut down on ED visits by improving the overall health of the severe and persistent mental illness and substance abuse disorder population in Connecticut.
- DMHAS has been drafting a **BHH** State Plan Amendment for submission to CMS with implementation planned in the first quarter of 2014. We have been developing this model in collaboration with the Departments of Social Services and Children and Families to provide primary care capable care coordination services to individuals with severe and persistent mental illness. As part of this process, DMHAS has been working with Medicaid service claims data, including primary care, behavioral health, and pharmacy, and is applying data analytics to determine eligible individuals, attribution, and baseline health statistics care costs.
- DMHAS currently has four **Assertive Community Treatment (ACT)** teams (Southeastern Mental Health Authority, Gilead, Community Mental Health Affiliates, and Community Health Resources). ACT teams require intensive staff-to-client ratios in order to serve individuals in the community who are often the most difficult to engage in services. Individuals served by ACT teams most often present with very complex needs, including co-occurring mental health and substance abuse, risk management concerns and legal complications. ACT is an evidenced-based practice that offers treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals that have been diagnosed with a severe and persistent mental illness. Assertive Community Treatment services include: assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support. These services are provided to individuals by a mobile, multi-disciplinary team in community settings. The goal of ACT services is to assist individuals to achieve their personally meaningful goals and life roles. We are in the process of bringing up more **ACT** teams in the state in order to cover more individuals who require a higher level of service across a wider geographic area. ACT teams can help to divert individuals from visiting the ED unnecessarily by giving them an alternative means of seeking assistance.
- Along the same lines DMHAS is currently developing a Request for Proposals, which will be published in the coming weeks, to solicit proposals for a **Peer Bridger program** to serve up to 100 individuals with mental health disorders or co-occurring mental health and substance use disorders who have a history of difficulty using traditional tools and services available in the current behavioral health system to gain a stable and fruitful lifestyle in the community. The **Peer Bridger Program** is a flexible community-based service that is capable of supporting individuals during daytimes, evenings and weekends. The peer supporters will be familiar with the resources available in the locales they serve in. Because some individuals are hospitalized, the Peer Bridger program will create strong working relationships with both the state inpatient facilities and private hospitals throughout the state.

DMHAS foresees this program, which utilizes Intentional Peer Support, an evidence based practice, as a way for peers to encourage peers to do what they can to access their version of recovery

- The **Crisis Recovery Collaborative** is a joint initiative between Rushford and River Valley Services to enhance crisis services for adults living in Middlesex County, Lyme, Old Lyme, Meriden and Wallingford. The collaborative provides 24-hour support, supervision and clinical treatment for individuals 18 years and older who are experiencing a mental health or emotional crisis and would benefit from assessment, crisis stabilization and referral services rather than hospitalization. The **Crisis Recovery Collaborative** allows for brief treatment to avoid hospitalization. Individuals can be directly admitted from inpatient care or from the community to prevent an unnecessary emergency department visit. The goal is to return individuals back to the community to continue their recovery in the least restrictive environment. The program is appropriate for those experiencing an emotional or mental health crisis; for those with a mental disability qualifying for pre- or post-hospitalization evaluation; or for those experiencing a crisis and need medication stabilization and linkage to other community based services.
- DMHAS **Mobile Crisis Teams** respond to mental health crises regardless of the socioeconomic status of the individual. CT has an existing Crisis Intervention Team network in most areas of the state, including CIT-trained police and clinicians. Individuals often require timely clinical interventions and community support. **Mobile Crisis Teams** are often the entry point for clinical services. Intake appointments are usually conducted during normal business hours while emergency crisis services are available seven days a week. Mobile Crisis staff are able to assist individuals in determining their eligibility. For people who do not need the type of services DMHAS offers, we can assist individuals in obtaining services with a group of local providers.
- **Crisis Intervention Teams** (CIT) are partnerships between the local police and the community provider network that offers training to law enforcement personnel and provides for a joint response to crisis in the community involving persons with behavioral health disorders. The goal of CIT is to reduce the need for arrest in favor of referrals to appropriate treatment resources. CIT has trained clinicians that work collaboratively with CIT trained officers to provide mental health evaluations and recommendations when responding to crisis calls.
- The DMHAS **Homeless Outreach Teams (HOT)** are designed to offer mental health and substance abuse services to individuals who are homeless. Everyday, staff from HOT go to local shelters, bus stations, train stations, parks, soup kitchens, and other locations to provide assistance and support to homeless individuals. Services that HOT provides includes: A "Drop-In" center where people can come have a cup of coffee or some food, staff who can help with medication management, an Employment Specialist who can help individuals find and keep a job, staff who can help clients get insurance, outreach workers who provide services in the community and can help with filling out housing applications or make referrals to shelters.
- The DMHAS **Community Support Program (CSP) and Recovery Pathways (RP) programs** utilize a team approach to provide intensive, rehabilitative community support, crisis intervention, individual and group skill-building, also known as recovery education. The majority of the interventions are community-based, delivered in the individual's home, neighborhood or community, which enables the team to become intimately familiar with the individual's surroundings, strengths and challenges, within the context of their environment. The desired outcome is to assist individuals toward an independent, enriched life based on their own choices and preferences.
- DMHAS recently submitted a proposal to SAMHSA and was awarded a grant for early intervention and jail diversion of young adults; the program is titled **Specialized CIT for Young Adults** (SCYA). SCYA will focus on providing enhanced CIT services to help engage young people in treatment. There are many reasons that treatment is not sought, or is refused, or is terminated prematurely: stigma, denial, concern about loss of freedom, and services that are unappealing or inadequate for young adults. This program is meant to encourage young adults to connect to treatment before a serious deterioration of their mental health occurs and that young person ends up in the custody of law enforcement or admitted to the ED. DMHAS anticipates that SCYA clients will be less likely to be

arrested, detained, or hospitalized in the future, and more likely to exhibit recovery through greater participation in work or school, and through lower rates of substance use.

- The **Community Call Line** at the DMHAS Office of the Commissioner (OOC) was established as a single point of contact for individuals seeking treatment, concerned family members and the general public. Community Call Line staff have expertise in behavioral health resources statewide as well as access to other DMHAS resources for individuals needing more specific and comprehensive expertise. Many of the calls concern individuals seeking detoxification from alcohol, opiates or other substances as well as individuals in need of mental health services. Community Call Line staff often obtain a face-to-face appointment or a telephone screening for admission to treatment programs, in place of unnecessary use of the EDs.
- DMHAS is playing a significant role in the design of State Innovation Model (SIM) in CT and has loaned 2 staff to this project: an Associate Director and an agency Program Planner.. SIM design has been funded by CMMI and will transform care delivery and payment models across commercial and public payers in CT. To achieve the tripartite aim of improved health, improved care delivery and reduced costs for healthcare, SIM will improve care coordination and access to community based services and deter individuals from seeking treatment unnecessarily in the ED.

We appreciate your time and attention to these matters and would be happy to answer any questions you may have.